

ACCESS

harm reduction

Guidance Document for Applicants

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Background

ACCESS (Advancing Cross-Cutting Engagement and Service Strategies) is a platform created by the Maryland Department of Health to centralize harm reduction resources provided by the Department to local health departments and community-based organizations. Local health departments and community-based organizations can visit the ACCESS website to learn about application opportunities, including opportunities for in-kind support and grants, and their relevant deadlines and background information. In addition, the website will direct applicants to web-forms through which they can apply for these resource opportunities.

For all questions regarding ACCESS, including application questions, please contact mdh.access@maryland.gov. The ACCESS webpage can be found at bit.ly/MDHaccess.

Purpose

Harm reduction programs often serve the needs of the population that are not engaged nor ready to engage in treatment. The 2014 National Survey on Drug Use and Health data show that 21.2 million Americans ages 12 and older needed treatment for an illegal drug or alcohol use problem in 2014. However, only about 2.5 million people received the specialized treatment they needed in the previous 12 months. ACCESS will create and strengthen harm reduction services that meet the needs of this population.

ACCESS is a centralized, web-based platform that will improve the ability of local health departments and community-based organizations to serve people who use drugs. The ACCESS website will provide information about opportunities to apply for in-kind harm reduction support, such as naloxone and fentanyl test strips, as well as grants. Eligible entities will be able to view application instructions, relevant deadlines, and background materials and then apply for resources as they are available.

ACCESS resources will support a broad range of activities that applies the harm reduction framework. Local health departments and community-based organizations that receive ACCESS resources must:

1. Provide services to people who are actively using drugs, without the expectation that they stop using drugs, and;
2. Engage people who use drugs in a non-judgmental and non-stigmatizing manner.

Public Health Crisis for People Who Use Drugs in Maryland

People who use drugs (PWUD) are at high risk for premature death and poor health outcomes.¹ This is driven by overdose², Hepatitis C virus (HCV), infections³, HIV⁴, and social determinants of health such as homelessness⁵, incarceration⁶, poverty⁷ and structural racism⁸.

¹ Shiels MS, Chernyavskiy P, Anderson WF, Best AF, Haozous EA, Hartge P, Rosenberg PS, Thomas D, Freedman ND, de Gonzalez AB. Trends in premature mortality in the USA by sex, race, and ethnicity from 1999 to 2014: an analysis of death certificate data. *The Lancet*. 2017 Mar 11;389(10073):1043-54.

² Hedegaard H, Warner M, Miniño AM. Drug overdose deaths in the United States, 1999-2016.

As opioid use has become more widespread, and the heroin supply increasingly adulterated, rates of morbidity and mortality in this population have increased significantly. This is particularly true in Maryland, where new HCV cases have increased by 55.8% from 2009 to 2015⁹, with the CDC attributing the overall rise in new HCV cases to the rise in injection drug use.¹⁰ The number of overdose deaths in Maryland has more than tripled since 2010, reaching 2,282 deaths in 2017.¹¹ 2009 of these deaths in the year 2017 were opioid-related. Compared to the 1,259 deaths in 2015, this represented a 81% increase statewide. Nationally, the increase from 2014 to 2015 was 11.4%, placing Maryland above the national average in overdose death rates every year from 2010 to 2015.¹² A major driver of opioid deaths has been fentanyl; fentanyl-related deaths rose by 42% in 2017.⁹

The reasons for low engagement with healthcare services among people who use drugs include self-stigma,^{13,14} perceived discrimination in healthcare settings,¹⁵ negative attitudes of providers towards people with substance use disorders¹⁶, structural barriers to participate in services¹⁷, and cultural competency among providers.⁶ These barriers to care perpetuate the poor health outcomes of PWUD; as a result, those who most need health and social services are often the least likely to get it.

In response to increasing opioid use and mortality, the Maryland Department of Health (MDH) has identified a need to engage with people who are using drugs, to provide services that

³ Zibbell JE, Asher AK, Patel RC, Kupronis B, Iqbal K, Ward JW, Holtzman D. Increases in acute hepatitis C virus infection related to a growing opioid epidemic and associated injection drug use, United States, 2004 to 2014. *American journal of public health*. 2018 Feb;108(2):175-81.

⁴ <https://www.cdc.gov/hiv/group/hiv-idu.html>

⁵ Linton SL, Celentano DD, Kirk GD, Mehta SH. The longitudinal association between homelessness, injection drug use, and injection-related risk behavior among persons with a history of injection drug use in Baltimore, MD. *Drug and alcohol dependence*. 2013 Oct 1;132(3):457-65.

⁶ Genberg BL, Astemborski J, Vlahov D, Kirk GD, Mehta SH. Incarceration and injection drug use in Baltimore, Maryland. *Addiction*. 2015 Jul;110(7):1152-9.

⁷ Walker ER, Druss BG. Cumulative burden of comorbid mental disorders, substance use disorders, chronic medical conditions, and poverty on health among adults in the USA. *Psychology, health & medicine*. 2017 Jul 3;22(6):727-35.

⁸ Bailey ZD, Krieger N, Agénor M, Graves J, Linos N, Bassett MT. Structural racism and health inequities in the USA: evidence and interventions. *The Lancet*. 2017 Apr 8;389(10077):1453-63.

⁹ Maryland Department of Health and Mental Hygiene. *2016 Annual Report Implementation of Hepatitis B and Hepatitis C Prevention and Control in Maryland Health-General Article §18-1002*.

¹⁰ <https://www.cdc.gov/hepatitis/statistics/2016surveillance/pdfs/2016HepSurveillanceRpt.pdf>

¹¹ Maryland Department of Health. Unintentional Drug- and Alcohol-Related Intoxication Deaths in Maryland Annual Report 2017. https://bha.health.maryland.gov/OVERDOSE_PREVENTION/Documents/Drug_Intox_Report_2017.pdf. Accessed: September 18, 2018.

¹² Rudd, R.A., Seth, P., David, F., Scholl, L. (2016) Increases in Drug and Opioid-Involved Overdose Death—United States, 2010-2015. *Morbidity and Mortality Weekly Report* 65(50-51):1445-1452.

¹³ Paquette CE, Syvertsen JL, Pollini RA. Stigma at every turn: Health services experiences among people who inject drugs. *International Journal of Drug Policy*. 2018 Jul 31;57:104-10.

¹⁴ Latkin C, Srikrishnan AK, Yang C, Johnson S, Solomon SS, Kumar S, Celentano DD, Solomon S. The relationship between drug use stigma and HIV injection risk behaviors among injection drug users in Chennai, India. *Drug and alcohol dependence*. 2010 Aug 1;110(3):221-7.

¹⁵ Paquette CE, Syvertsen JL, Pollini RA. Stigma at every turn: Health services experiences among people who inject drugs. *International Journal of Drug Policy*. 2018 Jul 31;57:104-10.

¹⁶ Van Boekel LC, Brouwers EP, Van Weeghel J, Garretsen HF. Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: systematic review. *Drug and alcohol dependence*. 2013 Jul 1;131(1-2):23-35.

¹⁷ Stopka TJ, Hutcheson M, Donahue A. Access to healthcare insurance and healthcare services among syringe exchange program clients in Massachusetts: qualitative findings from health navigators with the IDU ("I do") Care Collaborative. *Harm reduction journal*. 2017 Dec;14(1):26.

reduce overdose risk, and mitigate the impact of other negative health outcome of drug use. To address some of the reasons for low engagement among people who use drugs, these services must be provided applying a harm reduction framework.

Harm Reduction

A harm reduction approach has been demonstrated to most effectively engage those who are using drugs, particularly people who are not currently accessing somatic or behavioral health services. Programs applying this approach build strong relationships with the drug using community, which opens lines of communication about risk reduction strategies and overdose prevention. The Harm Reduction Coalition defines harm reduction as “Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs.”¹⁸ Providers who apply a harm reduction approach prioritize quality of life outcomes measures over abstinence. A focus on abstinence may ignore the myriad of social and other problems an individual faces not solely defined by their use of drugs. Other related tenets of harm reduction include ensuring the people who use drugs have a voice in the programs and policies that affect them, affirming that people who use drugs are the primary agents of change in their lives and seeking to empower them to support each other in risk mitigation strategies that actually relate to the conditions of their drug use.

Harm reduction services are provided without judgement of someone’s drug use status, meaning they are not required to stop or lessen their use of drugs in order to continue service engagement. This allows for a person-first approach, therefore meaningfully engaging people ongoing. This approach manifests in low-barrier/low-threshold services, mindful of reducing the steps people must take to access them. Finally, harm reduction approaches are “practical, feasible, effective, safe and cost-effective.”¹⁹

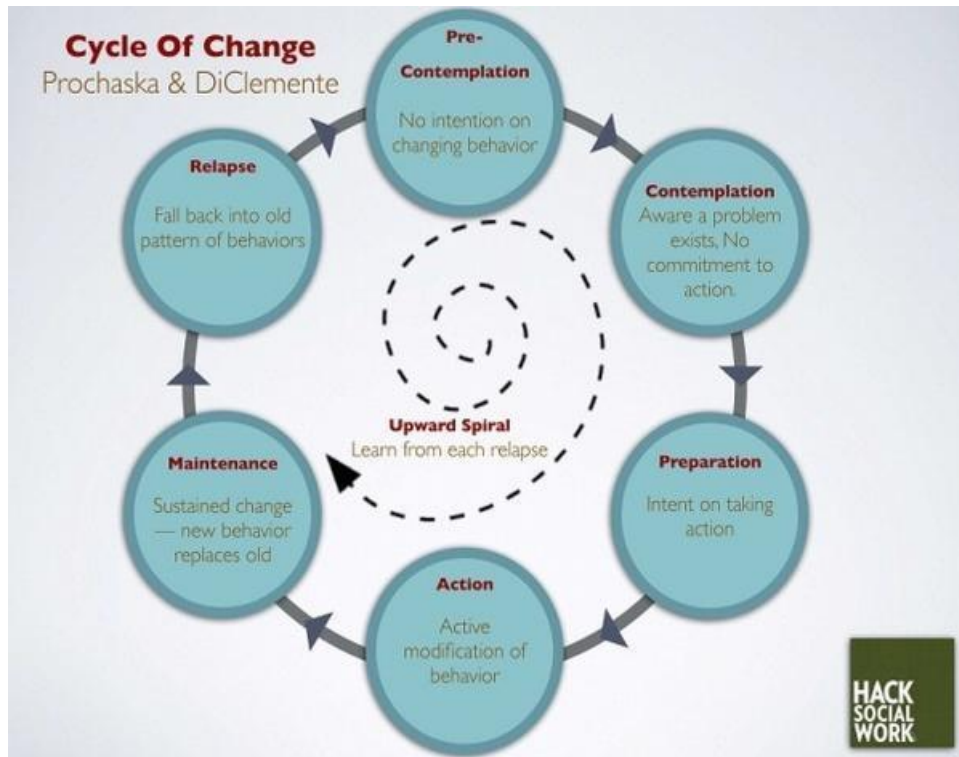
Meeting people where they are²⁰

Meeting people where they are requires understanding their lives and circumstances, what objectives are important to them personally, and what changes they can realistically make to achieve those objectives. For example, abstinence may not be immediately achievable by all who use illicit substances; however, many smaller changes may be feasible and could bring substantial benefit, such as reducing the spread of infectious disease, lowering overdose risk, and improving overall physical or mental health.

¹⁸ Harm Reduction Coalition. 2018. *Principles of Harm Reduction*. www. <https://harmreduction.org/about-us/principles-of-harm-reduction/>

¹⁹ Harm Reduction International. 2018. *Position Statement on Harm Reduction*. < <https://www.hri.global/what-is-harm-reduction>>

²⁰ Centers for Disease Control and Prevention. Evidence-Based Strategies for Preventing Opioid Overdose: What’s Working in the United States. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, 2018. Accessed [date] from <http://www.cdc.gov/drugoverdose/pdf/pubs/2018-evidence-based-strategies.pdf>



The Transtheoretical Model, also called the Stages of Change model, describes how such behavior change often occurs. The model emphasizes the need to understand the experience of the person we are trying to reach in order to help them. To promote change, interventions must be provided that are appropriate for the person's current stage in the process. The guiding principle of "meeting people where they are" means more than showing compassion or tolerance to people in crisis. This principle also asks us to acknowledge that all people we meet are at different stages of behavior change. Furthermore, recognition of these stages helps us set reasonable expectations for that encounter. For example, a person who has experienced an overdose who is pre-contemplative and has not yet recognized that their drug use is a problem may be unlikely to accept treatment when they are revived, but may benefit from clear, objective information about problems caused by their drug use and steps they can take to mitigate them. Unrealistic expectations that the person will cease drug use may cause frustration and disappointment for patients, providers, family, caregivers, and others touched by the event. Someone who is already preparing for action, however, may be ready for treatment, support, or other positive change. A positive, judgement-free encounter with first responders may provide the impetus and encouragement needed to get started. When we "meet people where they are," we can better support them in their progress towards healthy behavior change. Recognizing the progress made as a person moves forward through the stages of change can help avoid the frustration that arises from the expectation that they will achieve everything at once.

Naloxone

Naloxone is a life-saving opioid antagonist medication that can reverse the effects of an opioid overdose. It is available by prescription to people with a history of opioid use and to those that

might witness and respond to an overdose. Overdose education and naloxone distribution (OEND) programs aim to educate and distribute naloxone directly to community members. These programs contribute to a reduction in rates of opioid overdose death. For many years, naloxone has been made available to people using opioids through harm reduction programs like syringe services programs, community health programs, substance use disorder treatment providers, and others having direct contact with high-risk populations. Since 2014 in Maryland, naloxone has been distributed through the Overdose Response Program (ORP) by authorized training entities to people who, by virtue of their occupation, volunteer work, or family or social experience, are likely to be in a position to assist someone experiencing an opioid overdose.

OEND programs provide training on risk factors associated with opioid overdose, recognition of overdose signs and symptoms, and response techniques, including contacting emergency medical help, performing rescue breathing, and administering naloxone. Trainees are usually provided with a kit containing naloxone and the delivery device (nasal atomizer or needle and syringe) if needed, along with items such as non-latex gloves, a plastic shield for rescue breathing, and information cards on overdose prevention and response.

As authorized by Health – General Article Title 13, Subtitle 31, Code of Maryland, (ORP law) and implemented by regulations in COMAR 10.47.08, the ORP provides for training of individuals who, by virtue of their occupation or volunteer work, or family or social experience, are able to assist someone experiencing an opioid overdose. Authorized entities may conduct educational training programs on overdose recognition and response and provide access to naloxone through direct provision by a provider or through standing order. Naloxone is additionally available to Marylanders in pharmacies through a statewide standing order, which eliminates the need for an individual prescription.

The most effective OEND programs for reducing opioid overdoses in a community provide naloxone directly to people who use drugs, in a low-threshold setting²¹²². This is because people who use drugs, who are themselves at high risk for overdose, are most likely to witness an overdose.²³²⁴ Research in OEND programs has led to the recommendation that resource-limited programs should target OEND to people who use drugs.

There is a significant base of evidence to support targeted OEND to people who use drugs. OEND programs consistently receive the majority of their naloxone administration reports from people who use drugs. Research from the DOPE Project reported that having previously witnessed an overdose was the strongest predictor of reversing an overdose with naloxone, followed by the predictor of using heroin.¹⁸ In Massachusetts in 19 communities where

²¹ Rowe, C., Santos, G.M., Vittinghoff, E., Wheeler, E., Davidson, P., Coffin, P.O. (2015) Predictors of participant engagement and naloxone utilization in a community based naloxone distribution program. *Addiction* 110(8), 1301-1310.

²² Walley, A. (2013). Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis. *British Medical Journal*.

²³ Bennett, A.S., Bell, A., Doe-Simkins, M., Elliott, L., Pouget, E., & Davis, C. (2018) From Peers to Lay Bystanders: Findings from a Decade of Naloxone Distribution in Pittsburgh, PA. *Journal of Psychoactive Drugs*, 50(3), 240-246.

²⁴ Bagley, S.M. Forman, L.S., Ruiz, S., Cranston, K., Walley, A.Y. (2018) Expanding access to naloxone for family members: The Massachusetts experience.

naloxone was distributed between 2006 and 2009, people who use drugs were responsible for 87% of the 327 reported rescue attempts with naloxone.¹⁹ In a Pittsburgh needle exchange program, after naloxone was made available to individuals who do not use opioids themselves, the majority of reversals were still reported by people who use opioids (102 out of 104 reversals in 2015)²⁰. In a survey of organizations distributing naloxone, 82.8% of individuals who reported a naloxone administration to programs were people who use drugs; 9.6% were friends and family, 2% were services providers, and 7.4% were unknown.²⁵

With this research in mind, MDH has made it a priority for naloxone distribution to target people who use drugs and their associates. This strategy of targeting distribution to the population at risk themselves and most likely to witness an overdose has the greatest potential to prevent overdose deaths in Maryland.

Fentanyl Test Strips

Since 2014, large increases in overdose deaths in Maryland have been driven primarily by the pervasive adulteration of the illicit opioid (i.e. “heroin”) supply with fentanyl and fentanyl analogs. Fentanyl was involved in 77% of all overdose deaths in Q1 2018. The state has also seen a recent surge in cocaine-related deaths, which increased 313% between 2015 and 2017. This surge has been driven primarily by deaths from cocaine in combination with illicit opioids. In 2017, 71% of all cocaine-related deaths also involved fentanyl. There is a risk of overdose for both heroin and cocaine users, as well as people who use counterfeit “prescription” opioids.

Providing tools for people who use drugs to screen for the presence of fentanyl offers a promising opportunity to prevent overdose. A positive test provides critical knowledge to an individual who may then change their behavior in ways that reduce overdose risk, such as using less drugs, injecting more slowly or, in the case of cocaine-only users, not using at all. The strips are manufactured to test urine but are effective at identifying fentanyl in a small sample of powder drug mixed with water.

From BTNX, strips cost \$1 and are sold in boxes of 100. They have a high sensitivity and specificity for fentanyl and four of its analogs as compared to other testing devices. They are effective, legal, and safe to use.

Through Chapter 145 of the 2018 Laws of Maryland (SB1137), the Maryland General Assembly amended the Criminal Law Article with the intent to remove the threat of criminal sanctions for possession or distribution of testing equipment for the purpose of identifying a controlled dangerous substance. This was achieved through changes to the definition of “drug paraphernalia” and specific sections enumerating crimes and penalties associated with possession or distribution of drug paraphernalia. These changes to Maryland statute remove significant legal barriers to the distribution of fentanyl test strips for public health purposes.

²⁵ Wheeler, E., Jones, T.S., Gilbert, M.K., Davidson, P.J. (2015). Opioid Overdose Prevention Programs Providing Naloxone to Laypersons—United States, 2014. *Morbidity and mortality Weekly Report*, 64(23).

Resource and grant opportunities: eligibility criteria

1. Naloxone and Fentanyl Test Strips

Applications for overdose prevention resources (naloxone and fentanyl test strips) are open to the following types of MDH-authorized Overdose Response Program entities with active status and offices based in Maryland:

- a. Local health departments
- b. 501(c)(3) non-profit organizations

Applicants will be asked to submit proof of the organization's IRS nonprofit determination, for example, a nonprofit status determination letter.

Any MDH-authorized Overdose Response Program entity that meets the above criteria may apply for fentanyl test strips. However, only entities that have the following documentation on file with MDH allowing them to dispense naloxone may apply to receive naloxone:

- a. Licensed health care provider agreement
- b. Standing order
- c. Dispensing protocols

Training-only ORP entities are not eligible to apply for naloxone.

2. Harm Reduction Grants

MDH will accept applications for Harm Reduction Grants from:

- a. Local health departments
- b. 501(c)(3) non-profit organizations

Applicants will be asked to submit proof of the organization's IRS nonprofit determination, for example, a nonprofit status determination letter.

Application Process

Through ACCESS, MDH will provide resources, such as naloxone and grants, to eligible entities depending on availability and funding. There may be multiple opportunities to apply for different resources at one time. Application information will be made available at bit.ly/MDHaccess. **For all question regarding ACCESS opportunities and applications, please contact mdh.access@maryland.gov.**

1. Overdose Prevention Resources

When applications for Overdose Prevention Resources are open, a link will be provided to the webform application on the bit.ly/MDHaccess webpage. The link will be available under the "Overdose Prevention Resources" subheading. Only applications submitted through this webform will be accepted. When applications are open, a paper version of the application will be available on the webpage, to allow potential applicants to reference the questions before completing the webform. No paper form submissions will be accepted, however. Please note that the webform does NOT allow the user to leave the application, save the responses, and return at a later time.

2. Harm Reduction Grants

Local Health Departments:

MDH will issue a memo via email to the jurisdiction's health officers and health commissioners, requesting proposals. All proposals must be submitted by email to mdh.access@maryland.gov by May 20th, 2019, at 3:00 PM. A preproposal webinar will be held on April 26th at 1-2:30 PM. All questions should be directed to mdh.access@maryland.gov. Proposal requirements are as follows:

- I. Cover page
 - a. Applicant name
 - b. Applicant mailing address
 - c. Applicant shipping address, if different from mailing address (cannot be a PO box)
 - d. Signature and typed name of the jurisdiction's Health Officer or Health Commissioner
 - e. Name, title, email address, and phone number of contact person for the application
 - f. Date of submission
- II. Project Narrative: narratives, including scope of work and work plan, should be between 3 and 8 pages total, single spaced, excluding attachments
 - a. Agency Capacity: less than 1 page, excluding attachments
 - Briefly describe the broad activities and mission of your agency or program, including information about the population served. Identify the individuals within your agency who will be responsible for implementing the proposed activities. Include experience and capacity to provide services to people who use drugs and their associates. This may include staff experience conducting harm reduction work, the agency's policies and procedures that serve people who use drugs, and history of providing harm reduction services.
 - Provide a copy of your agency or program's organizational chart that includes staff relevant to the proposed project.
 - b. Scope of Work: less than 2 pages, single spaced

Describe the proposed project or proposed enhancements to an existing project, including the following components:

 - Need statement: describe the issue the proposed project addresses
 - Proposed project activities
 - Resources needed, including differentiating between what applicant is requesting funding for versus what is already in place
 - Population the project will serve
 - Evidence base for the proposed project and activities
 - c. Work Plan:
 - Provide a definitive description of the proposed plan to carry out the activities in the Scope of Work, i.e., a Work Plan. The Work Plan should include the specific methodology and techniques to be used by the applicant in providing the services outlined in the Scope of Work. The description shall include an outline of the overall management concepts employed by the applicant and a project

management plan, including project control mechanisms and overall timelines. Project deadlines considered grant deliverables must be recognized in the Work Plan.

- Note any ways that individuals with lived experience will have a role in project planning and/or implementation.
 - Note any project deliverables
 - Please use the provided Work Plan template, which can be found at the end of the guidance document in Appendix A.
- d. Evaluation: less than 1 page, single spaced
Describe what data will be collected to evaluate the project objectives described in the work plan, and how that data will be collected.

III. Budget

Local health departments will be asked to complete sheets a and b of the 4542 budget spreadsheet. Applicants should complete budgets for two separate periods of performance: July 1, 2019- June 30, 2020, and July 1, 2020 – September 30, 2020. All items included in the applicant’s budget should relate to activities described in the scope of work and/or work plan. For assistance completing the budget form, please provide a written description of your question or concern along with your contact phone number in an email to mdh.access@maryland.gov. Applicants who are selected for award will be required to complete the entire 4542 budget package. Please contact mdh.access@maryland.gov for the 4542 excel document.

Nonprofit organizations

A request for applications (RFA) with detailed proposal instructions will be posted on eMaryland Marketplace at <https://procurement.maryland.gov/> and circulated through local harm reduction listservs. Applications are due May 20, 2019 by 3:00 PM. **Applications must be mailed or hand-delivered to MDH. Emailed or faxed applications WILL NOT be accepted.** A preproposal webinar will be held on April 19th from 1:00 PM-2:30 PM.

Grant Applications Categories

Grants will support a broad range of projects with the goal of improving services and systems of care for people who use drugs. To organize proposals, MDH requests applicants indicate under which category their proposed project falls: direct services, first responder partnerships, and/or capacity building. Grant activities may fall into multiple categories.

A list of example projects and interventions is included in Appendix B (“Project Examples”). Proposals are not limited to this list, and applicants are encouraged to think creatively about new services, how to build capacity, and form partnerships to reach, engage, and serve people who use drugs.

1. Direct services to impacted populations

Direct services include interventions provided directly to people who use drugs. These may include but are not limited to: case management, substance use disorder treatment, crisis services, housing services, no-barrier drop-in services, and homeless services. Applicants may incorporate new services or enhance existing ones to better engage and/or serve people who use drugs.

This category also includes costs associated with the implementation of an Overdose Response Program to provide access to naloxone. If requesting ORP costs, include the number of doses of naloxone needed, but not the cost. Naloxone will be ordered by MDH and shipped directly to the grantee.

2. First responder partnerships

A variety of multidisciplinary overdose response and diversion models, led by first responders, have emerged in communities throughout the country. These models often include first responders working in partnership with service providers and peer recovery coaches to connect or link people who use drugs to needed services. Some examples of these projects include support for the planning and implementation of Law Enforcement Assisted Diversion (LEAD) and training, guidance, and materials for local EMS agencies providing naloxone leave-behind kits

3. Planning and capacity-building

Many worthwhile programs and projects require time for thoughtful and strategic planning to ensure successful implementation. The complexity associated with serving vulnerable and marginalized populations requires significant planning and capacity-building work. Examples of capacity building include requesting training for staff on engaging people who use drugs, sending staff to visit other similar programs, hiring of a consultant to review policies and protocols for improvements to better serve people who use drugs, and methods of engaging partners for program support. This also includes capacity building for implementation of a syringe services program.

Review and Scoring

All applications will be considered by a committee established for that purpose at MDH and decisions made based on the quality of the proposal, its alignment with MDH priorities that resources and services are provided directly to people who use drugs, and available funding. Specific measures include:

1. Fidelity to and commitment to harm reduction framework and evidence-based practices.
2. Plan for involving people with lived experience in project development and activities.

3. Quality and clarity of the proposal.
4. Existing capacity to perform the proposed activities, including organizational capacity as well as relationship with the target population.
5. Proposing to target and serve populations at highest risk for overdose and substance use related harms, as well as to reduce health disparities.
6. Strength of evidence of proposed activities.
7. Evaluation plans that will accommodate MDH requests for reports and other information
8. Appropriate timeline
9. Jurisdictional level of need, including rates of nonfatal overdose, overdose fatalities, and other health and drug use indicators

Award Information

1. Naloxone and Fentanyl Test Strips

Naloxone will be ordered by MDH and shipped directly to selected applicants by Cardinal Health. Applicants should be sure to provide an accurate shipping address where you can receive packages.

Fentanyl test strips will be purchased by MDH and then shipped or delivered by MDH staff to selected applicants.

2. Harm Reduction Grants

Local Health Departments

Local health departments will receive grants from the Maryland Department of Health. Grants will be provided to local addictions/core service/behavioral health authorities. Awards will be made for the project period from July 1, 2019 – September 30, 2020, split between FY20 (July 1, 2019 – June 30, 2020) and FY21 (July 1, 2020 – September 30, 2020).

Nonprofit Organizations

Nonprofit organizations will be funded through standard grant agreements with the Maryland Department of Health. Standard Grant Agreements require an annual risk assessment, quarterly progress reports, and quarterly invoicing for work complete to receive payment within the grant period. Payments are provided on a cost reimbursement basis. Awards will be made for the project period from July 1, 2019 – September 30, 2020, split between FY20 (July 1, 2019 – June 30, 2020) and FY21 (July 1, 2020 – September 30, 2020).

Conditions of Award

Before receiving ACCESS resources, all approved applicants will be required to sign and submit to MDH via email a memorandum of agreement (MOA) assuring that resources and grants will be used to serve people who use drugs. Local health departments and nonprofit organizations that are approved for Harm Reduction Grants may require additional agreements.

As a recipient of ACCESS resources and/or funding, the applicant must agree to the following terms and conditions:

1. All funded activities will be conducted with a harm reduction framework, including:
 - a. Provision of services to people who are actively using drugs, without the expectation that they stop using drugs; and,
 - b. Non-judgmental, non-stigmatizing engagement of people who use drugs.
2. All activities will be conducted in accordance with Maryland and federal law.
3. Services and resources provided to clients through this grant will be provided free of charge.
4. Entity staff will participate in monitoring activities by MDH as requested. This may include, but is not limited to, phone check-ins, surveys, and/or site visits by MDH to verify that project activities are being conducted in the manner proposed in the application.
5. Entity staff will provide detailed fiscal reports to MDH upon request.
6. In the event that MDH discovers project activities are not being conducted in the proposed manner, the entity will cooperate with MDH to redistribute any purchased resources and/or reimburse MDH and/or terminate the grant agreement.
7. In the event that MDH discovers application information was intentionally falsified or the entity was misrepresented, the entity will cooperate with MDH to redistribute any purchased resources and/or reimburse MDH and/or terminate the grant agreement.
8. Entity staff will participate in training and capacity-building activities as required by MDH.
9. Entity staff will notify MDH of any changes to relevant staff and project activities supported by the grant within 30 days of the change.

Contact Information

Please contact mdh.access@maryland.gov for any questions and concerns regarding ACCESS opportunities and applications. The ACCESS webpage can be found at bit.ly/MDHaccess.

Appendix A: Work Plan Template

Maryland Department of Health

Harm Reduction Grant Work Plan

July 1, 2019 – September 30, 2020

Work Plan Program Component: _____

Project goal: Reduce overdose deaths in the county by providing naloxone to people who use drugs who have experienced a prior overdose. Increase instances of bystander naloxone administration.		Measures of Effectiveness: <ol style="list-style-type: none"> 1. Percent of all EMS overdose responses where a naloxone kit was left behind 2. Percent of all EMS overdose response calls where naloxone had already been administered upon arrival. 3. 		
Objectives	Activities Planned To Achieve This Objective	Data	Time-frame for Assessing Progress	Team Members Responsible
Example: 1. By September 30, 2020, EMS will distribute naloxone kits and provide training and	<ol style="list-style-type: none"> 1. Partner with EMS LB program in neighboring county's EMS LB program to conduct 3 training sessions for EMS providers. 2. Develop an MOU for data-sharing and naloxone distribution with EMS 	1. Completed evaluation surveys from training sessions with EMS.	<ol style="list-style-type: none"> 1. Midway through FY20 (December 31, 2019) 2. Midway through FY20 (December 	Overdose Response Program Coordinator, EMS LB Program

information at 80 percent of all overdose scenes responded to.	<p>leadership.</p> <p>3. Equip all vehicles from <u> # </u> of the county's EMS providers with naloxone, and establish mechanism for replenishing supply.</p> <p>4. EMS providers dispense naloxone kits to individuals who overdosed and/or their families when responding to the scene of a drug overdose.</p>	<p>2. Signed MOU between EMS and County Health Department and protocols</p> <p>3. Excel spreadsheets extracted from emeds reports for each month tracking all overdose response cases and percent of cases where naloxone was left behind.</p>	<p>31, 2019)</p> <p>3. Monthly starting midway through project period (December 31, 2019)</p>	manager

Appendix B – Project Examples

Definitions:

- Harm reduction: providing services to people who use drugs without expectation that they stop using drugs. Engagement of people who use drugs is non-judgmental and non-stigmatizing.
- Low threshold: eliminating as many barriers as possible to care, such as intake procedures or drug abstinence requirements.
- Peer-based: programs that utilize individuals with lived experience to provide services.
- Housing First: model of providing housing as quickly as possible to individuals experiencing homelessness without barriers to entry such as abstinence from drug use, criminal background, or treatment service participation requirements.
- Medication First: programs that prioritize individuals receiving medication assisted treatment, such as buprenorphine or methadone, as quickly as possible, prior to assessment or treatment planning; medication is delivered without arbitrary tapering or time limits; psychosocial services are offered but not a requirement of treatment.
- Integration: making multiple services available at a single point of engagement.

Examples of Programs that Engage and Support People Who Use Drugs

Type of Program	Model Programs (<i>click on any for more information</i>)	Peer-reviewed articles and other resources
Low threshold drop-in space for people who use drugs/harm reduction services as engagement and access to care	<ul style="list-style-type: none"> • Washington Heights Corner Project, New York, New York • Lower East Side Harm Reduction Center, New York, New York • HIPS, Washington, D.C • Missouri Network for Opiate Reform and Recovery, St. Louis, Missouri • Wish Drop In Centre Society, Vancouver, Canada 	<ul style="list-style-type: none"> • McNeil R, Guirguis-Younger M, Dilley LB, Aubry TD, Turnbull J, Hwang SW. Harm reduction services as a point-of-entry to and source of end-of-life care and support for homeless and marginally housed persons who use alcohol and/or illicit drugs: a qualitative analysis. BMC Public Health. 2012 Dec;12(1):312. LINK
Comprehensive, harm reduction-based case management	<ul style="list-style-type: none"> • Law Enforcement Assisted Diversion (LEAD) model of case management 	<ul style="list-style-type: none"> • Clifasefi SL, Lonczak HS, Collins SE. Seattle's Law Enforcement Assisted Diversion (LEAD) program: Within-subjects changes on housing, employment, and income/benefits outcomes and associations with recidivism. Crime & Delinquency. 2017

Apr;63(4):429-45. [LINK](#)

**Law-Enforcement Assisted
Diversion**

- [Law Enforcement Assisted Diversion \(LEAD\)](#)
- National model with local program examples in Baltimore City and Washington County
- Multiple evaluations of various program components and outcomes available [here](#)

**Low threshold
buprenorphine
induction/prescribing**

- San Francisco Department of Public Health's Street Medicine Team's homeless outreach
- New York City primary care clinic
- Harm Reduction Coalition Buprenorphine Program, New York, New York
- Bhatraju EP, Grossman E, Tofighi B, McNeely J, DiRocco D, Flannery M, Garment A, Goldfeld K, Gourevitch MN, Lee JD. Public sector low threshold office-based buprenorphine treatment: outcomes at year 7. *Addiction science & clinical practice*. 2017 Dec;12(1):7. [LINK](#)
- Stancliff S, Joseph H, Fong C, Furst T, Comer SD, Roux P. Opioid maintenance treatment as a harm reduction tool for opioid-dependent individuals in New York City: the need to expand access to buprenorphine/naloxone in marginalized populations. *Journal of addictive diseases*. 2012 Jul 1;31(3):278-87. [LINK](#)

**Peer-based education
distribution of harm
reduction supplies**

- [New York Harm Reduction Educators](#)
- [Urban Survivor's Union](#)
- [The Peoples Harm Reduction Alliance](#)
- Latkin CA, Knowlton AR. Social network assessments and interventions for health behavior change: a critical review. *Behavioral Medicine*. 2015 Jul 3;41(3):90-7. [LINK](#)
- Latkin C, Donnell D, Liu TY, Davey-Rothwell M, Celentano D, Metzger D. The dynamic relationship between social norms and behaviors: the results of an HIV prevention network intervention for injection drug users. *Addiction*. 2013 May;108(5):934-43. [LINK](#)
- Marshall Z, Dechman MK, Minichiello A, Alcock L, Harris GE. Peering into the literature: A systematic review of the roles of people who inject drugs in harm reduction initiatives. *Drug and*

Alcohol Dependence. 2015 Jun 1;151:1-4. [LINK](#)

- Harm Reduction at Work: A Guide for Organizations Employing People who Use Drugs
- Good Practice Guide for Employing People Who Use Drugs

Housing First models	<ul style="list-style-type: none"> • The Open Door 	<ul style="list-style-type: none"> • Tsemberis S, Gulcur L, Nakae M. Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. American journal of public health. 2004 Apr;94(4):651-6. LINK
Programs aimed at providing support and connection to services for pregnant women and parents who are continuing to use drugs	<ul style="list-style-type: none"> • <u>Families in Recovery Combined Care Service (FIR)</u> • <u>The Dartmouth-Hitchcock Perinatal Addiction Treatment Program</u> 	<ul style="list-style-type: none"> • Poole N, Urquhart C, Talbot C. Women-centred harm reduction, gendering the national framework series (Vol. 4). Gendering the National Framework. 2010. LINK
Alcohol Management Programs		<ul style="list-style-type: none"> • Pauly B, Vallance K, Wettlaufer A, Chow C, Brown R, Evans J, Gray E, Krysovaty B, Ivsins A, Schiff R, Stockwell T. Community managed alcohol programs in Canada: Overview of key dimensions and implementation. Drug and alcohol review. 2018 Apr;37:S132-9. LINK • Podymow T, Turnbull J, Coyle D, Yetisir E, Wells G. Shelter-based managed alcohol administration to chronically homeless people addicted to alcohol. Canadian Medical Association Journal. 2006 Jan 3;174(1):45-9. LINK